Each edition of the IHCA Regulatory Beat features focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

**Involuntary Transfer/Discharge Issues**

If you haven’t already noticed, there has been a significant increase in federal CMS and Illinois Department of Public Health (IDPH) scrutiny over involuntary transfers and/or discharges (IVD). The increased survey activity with IVD is due to several reasons, including ombudsman and resident advocate outcry over their assertion that the number of involuntary transfers/discharges has significantly increased as well as hospitals complaining that they are having trouble finding LTC beds for discharges, including complaints that LTC facilities are unwilling to take residents back after a hospital stay. To impress upon LTC providers how seriously both CMS and IDPH have focused on IVD, there have been several LTC facilities cited with IVD tags, even at the “D” level, and have received fines over $3,000. Fines for “D” level deficiencies are rare. LTC providers need to thoroughly review both the current and new Requirements of Participation (RoP) regulations with regard to involuntary transfers/discharges to make sure they follow the requirements completely.

The current federal CMS regulations can be found under tags F201-F206 and F284. The new federal RoP requirements with regard to IVD can be found at tags F622-F626 and F660-F661. IDPH surveyors are reportedly surveying off the Interpretive Guidelines for these various federal regulations. The state of Illinois regulations for IVD (have not changed) can be found at Section 300.3300 (click here).

The involuntary transfer/discharge regulations have changed, but not dramatically. Facilities still can force a transfer/discharge only under one of six specified circumstances, and a resident continues to have the right to contest a proposed transfer/discharge in an administrative hearing. The revised regulations narrow the facility’s ability to base a transfer/discharge on a supposed inability to meet the resident’s needs, by requiring increased documentation by the resident’s physician. The regulations also limit transfer/discharge for nonpayment, by stating that nonpayment has not occurred as long as Medicaid or another third-party payor is considering a claim for the time period in question. All transfer/discharge notices must be sent to the resident, resident representative(s) and (in a new requirement) the Long-Term Care Ombudsman program. The revised regulations now explicitly state that a facility cannot discharge a resident while an appeal is pending.

**Justifications for Involuntary Transfer of Discharge**

Consistent with the federal statute (the Nursing Home Reform Law of 1987) and the previous regulations, the revised regulations allow a facility to transfer or discharge a resident against the resident’s will only in one of six specified situations:

- The facility cannot meet the resident’s needs;
- The resident no longer needs nursing facility services;
The resident’s presence endangers the safety of others in the facility;
- The resident’s presence endangers the health of others in the facility;
- The resident has failed to pay; or
- The facility is closing.

The revised regulations have modified the “safety” justification by specifying that the endangerment must be due to the resident’s “clinical or behavioral status.” It’s unclear whether this change is particularly meaningful: whenever a facility claims a threat to safety, the allegations generally concern the resident’s clinical conditions or behavior.

The revised regulations now state that a resident cannot be transferred or discharged for nonpayment if he or she has “submit[ted] the necessary paperwork for third party payment.” This provision is particularly relevant for a resident applying for Medicaid coverage. While the Medicaid program is considering the resident’s application, the facility cannot initiate a nonpayment transfer/discharge action. This protection previously had been set forth in the surveyor’s guidelines, but now CMS has elevated that protection to the regulations.

**Required Notice**

Consistent with the statute and the previous regulations, the revised regulations require that the facility provide written notice of the proposed transfer/discharge to the resident and the resident’s representative(s). A new provision requires that notice also be sent at the same time to the Long-Term Care Ombudsman program.

The revised regulations specify that the notice be written in a “language and manner” understood by the resident and representative(s). The notice must include:

- The reason for the transfer/discharge,
- The proposed effective date,
- The location to which the resident will be transferred or discharged,
- Information on the resident’s appeal rights, and
- Contact information for the Long-Term Care Ombudsman program and (if applicable) the agencies responsible for advocacy on behalf of persons with intellectual and developmental disabilities, or persons with mental disorders.

Notice generally must be given at least 30 days before the proposed transfer/discharge. Notice can be made “as soon as practicable before transfer or discharge;” however, if the resident has resided in the facility for less than 30 days, if the resident’s improved condition allows for a “more immediate transfer or discharge,” or if prompt transfer or discharge is needed to protect the safety or health of others at the facility, or to respond to the resident’s “urgent medical needs.” The term “as soon as practicable” is not defined but, in any case, the resident cannot be transferred or discharged while an appeal is pending, unless delay will endanger the health or safety of the resident or others in the facility.

If the information in the notice changes, the facility must let the resident and resident representative(s) know of that change as soon as practicable. This regulatory change now states that the facility has a clear obligation to update information. However, it is still unclear about restarting the notice period after a change has been made.

**Required Documentation**

Most of the documentation requirements are consistent with the statute and the previous regulations. If a proposed transfer/discharge is based on an alleged danger to safety or health, the need for the transfer/discharge must be clearly and completely documented by a physician. If transfer/discharge is based upon the resident’s needs — either needing care that the facility cannot provide, or not needing nursing facility care — this documentation must be done by the resident’s physician.

In addition, a new provision applies specifically to transfer/discharge based on the resident allegedly needing care that the facility cannot provide. In these situations, the resident’s physician must document:

- Specific need(s) that the facility allegedly cannot meet,
- Attempts by the facility to meet the need(s), and
- Services available at the receiving facility that supposedly will meet the need(s).
Also, the facility needs to be aware of similar admissions/situations in the past so as not to create a ‘Catch-22’ situation for itself.

This documentation requirement was added in hopes that it would deter a facility’s inclination to transfer residents who are perceived as being difficult or “heavy care,” but whose care needs fall within the level of service required by federal law. Since this documentation requirement is new, it will not become effective until November 28, 2017. The other documentation requirements are not new and so are already in effect.

**Appeal Rights**
The resident has the right to appeal any proposed transfer/discharge. A new provision requires the facility to assist the resident if the resident needs help in completing and submitting a request for an appeal.

Appeals are governed by the same regulations that apply to Medicaid hearings, and those regulations were untouched by this round of regulatory changes. Residents continue to have a right to examine relevant documents prior to the administrative hearing and to cross-examine adverse witnesses.

As mentioned above, a facility cannot carry out an involuntary transfer or discharge while an appeal is pending.

**Discharge Planning**
Other provisions of the nursing facility regulations (F660 –F661) require that a facility have a discharge plan for each resident, and provide an explanation whenever discharge from the facility is not considered feasible. The transfer/discharge regulations include a separate provision, retained from the previous regulations, that requires the facility to provide sufficient preparation and orientation to ensure a safe and orderly transfer or discharge. The orientation “must be provided in a form and manner that the resident can understand.”

**Ombudsman Notice**
A facility must provide notice to the resident, resident representative and the Ombudsman for all facility-initiated transfers and discharges. While notice to the Ombudsman is required for all facility-initiated transfers and discharges, the time frame in which the facility is required to provide the notice can vary depending on the circumstances.

- When a resident is on a therapeutic leave or is transferred to the hospital with the intent to re-admit the resident, the facility can group these notices and send them or give them to the Ombudsman on a monthly basis.

- If a facility transfers a resident to a hospital with the original intent of re-admitting them, but circumstances arise that the facility decides to not take the resident back before being discharged from the hospital, the facility must then comply with all the IVD requirements at 42 CFR 483.15 (including appeal rights), including providing an appropriate notice at least 30 days before discharge or as soon as practicable, when appropriate to the resident, resident representative and the Ombudsman.

- Any facility initiated involuntary transfer/discharge requires immediate 30 day or emergency transfer/discharge notice to the resident, resident representative and the Ombudsman.

**Effective Dates**
Almost all of the provisions relating to involuntary transfer/discharge became effective on November 28, 2016. The exception is the requirement that the resident’s physician provide extra documentation when the facility claims that it cannot meet the resident’s needs. This requirement will become effective on November 28, 2017.

**Recruitment and Retention Tips Direct From Frontline Workers**
When I was in college, I took a job as reporter at our student newspaper toward the end of my freshman year. I hadn’t taken any journalism classes yet, except for an incredibly basic introduction to mass communication class where we learned what year the printing press was invented and how radios worked.
I thought this would put me at a disadvantage — I hadn't done any journalism class assignments yet, so how would I learn how to report? I took the job anyway and had a bit of a revelation a year later when I entered my university's journalism school and began taking classes: The best education wasn't the one I had sitting in a classroom — it was the hands-on experience I got talking to editors and sources through my reporting job.

I think the same philosophy can be applied to a lot of the education sessions providers attend at local and national conferences. It's not that the information presented there isn't valuable; it's just a different type of education than learning the concepts through hands-on experiences, or by talking with employees or residents directly.

Attendees at the Pioneer Network Conference held this week in Rosemont, IL, got a chance to experience that latter type of education on one of the most pressing topics in the long term care industry: employee recruitment and retention.

Sue Misiorski, national director of coaching and consulting for PHI, the group dedicated to improving conditions for direct-care workers such as nurse aides, moderated a panel of four CNA care partners from senior care and living organizations in the Chicago and Boston areas. The idea of the panel, which was called “In Their Own Voice: A Conversation with Care Partners about Recruitment and Retention,” was to identify “what's hard” about recruitment and retention and figuring out what, “if we made a couple of tweaks, doesn't have to be so hard,” Misiorski explained.

The issue is especially pressing since the number of adults over the age of 65 is expected to increase 128% by 2050. The number of working women in the age demographic most likely to take frontline care jobs is projected to grow by only 20%, Misiorski said.

“We need to understand what we can do as employers to make a workplace as person-centered for [workers] as it is for the elders,” she added.

When asked what drew the employees to their job, the panelists gave a variety of responses ranging from flexibility to set their own schedule and opportunities for advancement and managerial roles to word of mouth from other employees or the community that a facility was a welcoming, home-like place to work. That last bit is critical, Misiorski emphasized.

“What is your brand as an employer? I don't think we often think of that in our field. We think of our brand of caring.”

Misiorski also asked what keeps them around when other employees may leave. The number one response was the residents, followed closely by the relationships they have forged with their supervisors and co-workers.

“It's a family there,” one panel member said. “We don't consider it a job. We consider it daily living. I find joy in that.”

The panel also explained that self-scheduling and schedule flexibility, opportunities for education such as vocational and nursing programs, and control over their day-to-day responsibilities have also kept them anchored to the same organization year in and year out.

But some employees do eventually leave, with many — as many as 75% of workers — quitting due to issues with their supervisors, Misiorski said.

The panel responded that communication is key to creating a good employee-supervisor relationship, from being open to what's going on on the nursing floor to their overall vision for the organization. Approachability also emerged as a common theme, with the CNAs finding they worked best with leaders whom they felt they could come to with issues without having to worry about being reprimanded.

Treating every level of employee with the same level of respect, being accountable and relatable, and taking a “hands-off” approach to empowering workers rounded out the reasons why the panel has stuck with their supervisors for as long as they have.
Panelists explained that while their organizations have impressively low turnover rates due to their leadership teams and structure, the same structure that drew them in could drive other workers away. One of the Boston-area CNAs gave the example of the resident-centered structure at her facility; residents can choose when they get up, eat, shower and generally go about their days. While that focus on the resident as a person keeps her engaged at work, it was a turnoff for some workers who would have preferred to get residents up and ready by 9 a.m. each day.

Employees who leave because they aren't a good fit for the facility's structure “are the people you wouldn't really want there in the first place,” Misiorski noted.

The panel concluded with each CNA offering up something that would make their workplaces even better. The responses ranged from holding more staff meetings to granting employees more say in budgeting and menu planning. They also recommended teaching new employees the importance of not just sticking with their daily work assignments, and offering a hand to others when needed.

Panelists also said that attending conferences has brought value not only to them but also to their organizations. One CNA, for example, came back from a conference with information from a session on reducing alarms; she taught her coworkers, and the facility eventually eliminated alarms entirely.

So take the panel’s advice, and listen to the voices of your frontline staff. From improving communication and schedule flexibility, to investing in continuing education and conference trips, understanding what motivates your staff may just drive them to stick around.

**Authored by Emily Mongan and reprinted out of McKnight’s.**

**Top 5 Facts About the New CMS RoP Regulations and Your Dietary Department**

The Centers for Medicare & Medicaid Services updated and finalized their mega-rule regulations last year. Some of the new regulations pertaining to registered dietitians and food service include the education level of the dietitian, the food service manager and staff.

To begin, CMS has revised and expanded the Dietary Services Title §483.35 to Food and Nutrition Services §483.60. The regulations have added a support staff section which requires facilities to provide sufficient personnel to safely and effectively carry out the functions of the food and nutrition services.

Next, facilities are mandated to have either a full time RD (Registered Dietitian) certified by the commission (or licensed by the state), or employ a certified dietary manager with a consulting dietitian. The facility must ensure that all staff has the competency and skill sets for the population. Many of these positions require a bachelor's degree in the related field of study.

A food and nutrition staff member is now required to be a member of the interdisciplinary team. Facilities must provide each resident with palatable well-balanced meals three times daily in concordance with their special nutritional needs, with no longer than 14 hours between a sufficient evening meal and the morning meal.

Providers also must take into consideration any special dietary requests as related to the patients' ethnic, cultural, religious or other preferences of their specific population. Facilities must provide appetizing and appealing alternative options not only in food, but now also in beverages.

Finally, in accordance with state laws, the new regulations allow for the attending physician to authorize the RD to prescribe diets. Consistent with the previous regulations, facilities must provide the necessary assistive eating devices as well as properly trained eating assistive staff. Facilities have been granted the ability to provide their own homegrown food sources as well as food from local producers according to the new food safety provisions, though food must still be properly prepared and distributed to the population.
As the healthcare industry evolves with our aging population and the expected changes in applicable federal law, we can expect further changes to the regulations and with that, changes to the demands of the dietitian and associated staff.

Authored by Janet Feinstein RD, LD, CNSC and reprinted out of McKnight’s.

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*

**Nine Lifestyle Changes Can Reduce Dementia Risk, Study Says**

One in three cases of dementia could be prevented if more people looked after their brain health throughout life, according to an international study in the *Lancet*.

It lists nine key risk factors including lack of education, hearing loss, smoking and physical inactivity.

The study is being presented at the *Alzheimer's Association International Conference* in London.

By 2050, 131 million people could be living with dementia globally.

There are estimated to be 47 million people with the condition at the moment.

**Nine factors that contribute to the risk of dementia**

- Mid-life hearing loss - responsible for 9% of the risk
- Failing to complete secondary education - 8%
- Smoking - 5%
- Failing to seek early treatment for depression - 4%
- Physical inactivity - 3%
- Social isolation - 2%
- High blood pressure - 2%
- Obesity - 1%
- Type 2 diabetes - 1%

These risk factors - which are described as potentially modifiable - add up to 35%. The other 65% of dementia risk is thought to be potentially non-modifiable.

*Source: [Lancet Commission on dementia prevention, intervention and care](https://www.thelancet.com/commissions)

"Although dementia is diagnosed in later life, the brain changes usually begin to develop years before," said lead author Prof Gill Livingston, from University College London.

"Acting now will vastly improve life for people with dementia and their families and, in doing so, will transform the future of society."

The report, which combines the work of 24 international experts, says lifestyle factors can play a major role in increasing or reducing an individual's dementia risk.

It examines the benefits of building a "cognitive reserve", which means strengthening the brain's networks so it can continue to function in later life despite damage.

Failure to complete secondary education was a major risk factor, and the authors suggest that individuals who continue to learn throughout life are likely to build additional brain reserves.
Another major risk factor is hearing loss in middle age - the researchers say this can deny people a cognitively rich environment and lead to social isolation and depression, which are among other potentially modifiable risk factors for dementia.

Another key message from the report is that what is good for the heart is good for the brain.

'Positive changes'

Not smoking, doing exercise, keeping a healthy weight, treating high blood pressure and diabetes can all reduce the risk of dementia, as well as cardiovascular disease, and cancer.

The researchers say they did not have enough data to include dietary factors or alcohol in their calculations but believe both could be important.

Dr. Doug Brown, director of research at Alzheimer’s Society, said: "Though it's not inevitable, dementia is currently set to be the 21st Century's biggest killer. We all need to be aware of the risks and start making positive lifestyle changes."

Dr. David Reynolds, chief scientific officer at Alzheimer's Research UK, said: "Alongside prevention research, we must continue to invest in research to find a life-changing treatment for people with this devastating condition."

Reprinted out of BBC Health News.

**Important Regulations, Notices & News Items of Interest**

1) The following new federal Survey and Certification (S&C) Letter was released since the last issue of Regulatory Beat:

   - S&C 17-43 – All - Quality and Certification Oversight Reports (QCOR) Website Launch. New Website Platform and Data System: CMS is releasing information related to the new QCOR website in an overarching initiative for increased transparency.

2) Federal HHS/CMS released the following notices/announcements:

   - Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — Thursday, September 7 from 12:30 to 2 pm CST. Register for Medicare Learning Network events. During this call, learn about the new Facility Assessment Tool to help identify and develop the specific assessment of your facility. Also, find out about frequently asked questions related to revision of the State Operations Manual Appendix PP for Phase 2 of the Reform of Requirements for Long-Term Care Facilities final rule. A question and answer session follows the presentation.

   - CMS Survey Forms Released. CMS released new survey forms, including a new entrance conference worksheet and facility matrix, as well as new and updated investigative protocols, referred to as pathways, which will be used for the new long term care survey process that starts on November 28, 2017. These forms are posted on the CMS Nursing Homes webpage here. You can also access them on the AHCA/NCAL website here as well as on ahcancalED, which is here in RequirED under CMS Resources.

   Although the pathways are designed to be used by surveyors during the survey process, they can be used by nursing center staff as tools to assess compliance with regulations and identify systems and areas of care delivery needing improvement. AHCA is hosting a webinar on September 25, 2017, 1:00 pm - 2:00 p.m. Eastern, "Preparing for the New Survey Process and Requirements of Participation Phase 2." The webinar will
provide information on what to expect in the new survey process and provide updates on materials available from CMS as well as AHCA tools and resources to help implement new Phase 2 requirements. Register for the webinar here. For questions about the new survey process, forms, pathways, requirements, or interpretive guidance, email CMS at NHSurveyDevelopment@cms.hhs.gov. For additional information, email AHCA's Sara Rudow here.

- **CMS Launches Jimmo Settlement Agreement Webpage.** Looking for information about the Jimmo Settlement Agreement? Visit the new Jimmo Settlement Agreement webpage for:
  - Background on the settlement
  - Links to resources
  - Frequently Asked Questions (FAQs)

CMS reminds the Medicare community of the Jimmo Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare’s skilled nursing facility, home health and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the Jimmo Settlement required manual revisions to restate a “maintenance coverage standard” for both skilled nursing and therapy services under these benefits:

  - Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.
  - Skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The Jimmo Settlement may reflect a change in practice for those providers, adjudicators and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Settlement is consistent with the Medicare program’s regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.

- **CMS Provider Minute: Preventive Services Video.** Proper payment and sufficient documentation go hand in hand. The CMS Provider Minute: Preventive Services video includes pointers to help you avoid claim denials. Learn how to submit the correct documentation for:
  - Time spent providing a service
  - Record of billed service
  - Physician signature

This video is part of a series to help providers of all types improve in areas identified with a high degree of noncompliance.

- **IMPACT Act: Medicare Spending Per Beneficiary Measures Call — Wednesday, September 6, 12:30 - 2 p.m. CST.** Register for Medicare Learning Network events. During this call, CMS and measure developers present information on the adopted Medicare Spending per Beneficiary Post-Acute Care (PAC) resource use measures, focusing on the components of each measure, as well as public reporting. A question and answer session follows the presentation. The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires the development of resource use measures for PAC providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.
- **Qualified Medicare Beneficiary Program Billing Rules Call** — Tuesday, September 19, 1:30 - 3 p.m. ET. Register for Medicare Learning Network events. During this call, CMS experts discuss the Qualified Medicare Beneficiary (QMB) billing rules and their implications. Find out about upcoming changes to the HIPAA Eligibility Transaction System (HETS) and remittance advice to identify the QMB status of your patients and exemption from cost-sharing. Also, learn key steps to promote compliance. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays. Visit the Medicare-Medicaid General Information webpage for more information.

- **Reporting Hospice Quality Data: Tips for Compliance Call** — Wednesday, September 20 from 1:30 to 3 pm ET. Register for Medicare Learning Network events. During this call, learn more about Hospice Quality Reporting Program requirements. Find out how to be compliant and successfully submit Hospice Item Set (HIS) data and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey in the next reporting year. A question and answer session follows the presentation. Topics:
  - HIS and CAHPS® submission requirements
  - Reasons for noncompliance and how to address them
  - Timelines for data submission and compliance determinations
  - Resources for success, including how to access important websites and helpdesks

- **PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call** — Tuesday, September 26, 1:30 - 3 p.m. ET. Register for Medicare Learning Network events. Learn about Physician Quality Reporting System (PQRS) downward payment adjustments, PQRS feedback reports and the informal review process for Program Year (PY) 2016 results and 2018 payment adjustment determinations. Note: 2016 was the last program year for PQRS. PQRS transitioned to the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program. The final data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. The first MIPS performance period is January through December 2017. For more information, visit the Quality Payment Program website. This event is being evaluated by CMS for CME and CEU continuing education credit (CE). Check the event webpage for CE Activity Information & Instructions.

- **Chronic Care Management Services Changes for 2017 Fact Sheet** — Reminder. A revised Chronic Care Management Services Changes for 2017 Fact Sheet is available. Learn about:
  - 2017 coding changes
  - Key improvements reducing requirements associated with initiating care

- **Update: SNF Review and Correct Report & Confidential Feedback Report Issues**. CMS recently notified Skilled Nursing Facility providers that they found two issues in their technical coding of the Review and Correct Report, one of which also affected the Confidential Feedback Report (due for release in October).

- **Hospice Compare Update Document Available**. CMS posted a new Hospice Compare Update document with guidance on how to update provider demographic information, including address, telephone number and state Automated Survey Processing Environment (ASPEN) coordinator ownership. The document also includes information on the cutoff dates for changes to demographic information for Hospice Compare. Visit the Hospice Quality Public Reporting webpage for more information.

- **IMPACT Act Call: Audio Recording and Transcript** — New. An audio recording and transcript are available for the August 17 call on the IMPACT Act: Drug Regimen Review Measure Overview for the Home Health Quality Reporting Program. The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires reporting of standardized patient assessment data.

- **Preventive Services Poster Educational Tool** — Revised. A revised Preventive Services Poster Educational Tool is available. Learn about:
  - Coding
### Coverage requirements
- Patient cost-sharing for each Medicare preventive service

### Medicare Costs at a Glance: 2017 Educational Tool — Reminder

### Telehealth Services Fact Sheet — Reminder
A [Telehealth Services](#) Fact Sheet is available. Learn about:
- Originating sites
- Distant site practitioners
- Telehealth services
- Billing and payment

3) The federal [Agency for Healthcare Research and Quality (AHRQ)](#) reported on:

- **Ensuring the Safety of Health Information Technology is a Shared Responsibility.** An article by AHRQ-funded authors urges that health information technology (IT) vendors, care providers, health care organizations, health IT departments and public and private agencies take complementary roles and share responsibility in improving patient safety related to the use of electronic health records (EHR). The authors, writing in *Healthcare: The Journal of Delivery Science and Innovation*, use real-world examples to guide development of rules, regulations and standards for EHR usability, interoperability and security. The article follows a 2011 Institute of Medicine report on health IT and patient safety that defined the responsibilities of each party and suggests measures for success. In this article, the authors call on national and international policymakers to take steps to stimulate the adoption of shared responsibility principles. Access the [abstract](#).

- **Handoff Improvement Program Results in Patient Safety Gains.** Implementation of I-PASS — an evidence-based program designed to teach, evaluate and improve patient handoffs between providers and settings – has led to substantial gains in patient safety and can be applied to a variety of disciplines and types of handoffs, according to new research partially funded by AHRQ. Researchers and clinicians developed I-PASS to reduce medical errors and adverse events associated with handoff communication failures. When initially implemented in nine pediatric hospital units, I-PASS was associated with a 30 percent reduction in injuries and significant improvements in handoff processes. AHRQ subsequently funded the I-PASS Mentored Implementation Program to adapt and implement I-PASS to other clinical settings and types of providers across 35 hospitals. Sixteen hospitals that have completed implementation showed significant improvements in the quality of handoffs, as well as significant reductions in handoff-related adverse events. Implementation is underway at the other 19 hospitals. Authors of the new study, published in *The Joint Commission Journal on Quality and Patient Safety*, concluded that widespread implementation of I-PASS has the potential to substantially improve patient safety in the United States and beyond. Access the study [abstract](#). The research follows the development of an intervention on “warm handoffs” that will become part of AHRQ's [Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families](#). Warm handoffs are those that occur transparently in the presence of patients and family members.

4) The [HHS Centers for Disease Control and Prevention (CDC)](#) noted:

- **2017-2018 Flu Season Vaccine Recommendations.** CDC published an MMWR on Thursday, August 24, containing influenza vaccine recommendations for the 2017-2018 season. This report updates the 2016-2017 recommendations of the Advisory Committee on Immunization Practices (ACIP) regarding the use of seasonal influenza vaccines. Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. A licensed, recommended, and age-appropriate vaccine should be used.
• **Register for the VIC Webinar.** Mark your calendar for Wednesday, August 30th and REGISTER for the VicNetwork webinar. Speakers will provide important information that you will want to know about what’s new with this year’s flu vaccine along with updates on the communication plans by the CDC and new resources that will help you with your flu vaccination promotion efforts.

5) The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) recently published their August 2017 issue of The Express, which provided several articles of interest. They include New Tools for HHCs, an Upcoming Webinar on Preparedness, other newly released ASPR TRACIE Webinars, CMS Emergency Preparedness Rule Reminders, Cybersecurity Updates and other related information.

6) The HHS Office of the Inspector General (OIG) reports on **Early Alert: Potential Abuse or Neglect at Skilled Nursing Facilities.** This OIC Early Alert provides the preliminary results of our ongoing review of potential abuse or neglect of Medicare beneficiaries in skilled nursing facilities (SNFs). The audit is part of the ongoing efforts of the Office of Inspector General to detect and combat elder abuse. The objectives of our audit are to identify incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs and determine whether these incidents were reported and investigated in accordance with applicable requirements.

7) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of Regulatory Beat:

- **Corrected August - October ACA FFS Payment Calculation Sept ACA FFS Payment Calculation.** An incorrect calculation of the FFS ACA payments for Aug-Oct was posted to the Department’s Website. They will adjust the Sept payment to account for the incorrect August payments. They still need to remove the incorrect file and replace it with two files:
  - The correct quarterly payment calculation
  - The adjusted Sept payment calculation

- HFS posted a new provider notice regarding **Self-Disclosure Protocol.** You may view the notice [here](#).

- **Public Notice - Specialized Mental Health Rehabilitation Facilities Rate Increase** ([click here](#)).

- **Reminder:** [HFS-Office of Inspector General’s Self-Disclosure Protocol](#). This protocol is to be used by all Medical Assistance Providers. All self-disclosures received that do not comply with this protocol will be returned to the Provider for compliance based upon the current Department protocols.

- **08/25/17 Public Notice - ID/DD Facility Rates - Wage Increase** ([click here](#)).

- HFS posted a new provider notice regarding **Personal Needs Allowance Increase Effective 7-1-17.** You may view the notice [here](#).

8) The Illinois Department of Public Health (IDPH) reports:

- The **2017 IDPH Town Hall Meeting Schedule.** Letters will be sent to the individual facilities in the regions prior to each meeting. Instructions for responding (will be included in the letter) or you can RSVP ([at least three days](#) before the scheduled meeting) to Lisa Reynolds via email at: [lisa.reynolds@illinois.gov](mailto:lisa.reynolds@illinois.gov). Please include the date and location of the meeting in the Subject Line.
  - September 28, 1-3 PM | Washington County Hospital | 705 South Grand Ave, Nashville, IL
  - October 24, 1-3 PM | Knox County Nursing Home I 800 North Market Street, Knoxville, IL
  - November 30, 1-3 PM | Dupage Convalescent Center | 400 North County Road, Wheaton IL 60817
9) The Illinois State Long-Term Care Ombudsman Program noted that the new Ombudsman Poster on Resident’s Rights is being printed and should be available in the very near future. When it becomes available, we will bring it to the attention of our members.

10) The American Health Care Association (AHCA) and Illinois Health Care Association (IHCA) recently reported on:

- Governor Rauner Signs Several Bills Into Law (click here).

- CMS Announces Emergency Changes to SNF QRP Deadlines Due to System Problems. AHCA received notification from CMS that it is making significant changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP) reporting deadlines, as well as report availability, due to system coding issues. The specific reports impacted are the Review and Correct Report and Confidential Feedback Report that SNFs use to help monitor compliance with MDS 3.0 assessment-based quality measures, and identify assessments that may need updating.

- Don’t Miss the LTC Trend Tracker Back to School Webinar on September 13, 2017 - 2:00 pm - 3:00 pm Eastern - Register today! LTC Trend Tracker is back in session - we've shared with you how to run reports and upload data into the tool, but what do you do next? How do you use reports to improve your organization's performance? Join the LTC Trend Tracker team for our Back to School webinar to find out more!

- Hurricane Harvey Update. Over the past several days, we have all been watching and reading reports about the devastation caused by Hurricane Harvey in Texas and along the Gulf Coast. In these kinds of situations, we consistently hear of selfless acts by caregivers who prioritize their residents over their own families and personal property. We see our centers and communities step up to help in times of need, making space for residents who need to be evacuated. I am grateful for each and every one of our members and the way we come together in times of need.

- IMPORTANT RoP SURVEY INFORMATION - SNF Facility Assessment Information Posted. An optional template is available to help facilities comply with the new requirement that “Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents (§483.70(e)).” The Facility Assessment Tool will be discussed during the Medicare Learning Network event scheduled for Thursday, September 7, 1:30 - 3:00 p.m. ET. Registration is required for Medicare Learning Network events. Register here. This call will include an overview of the new Facility Assessment Tool developed by the Quality Innovation Network National Coordinating Center (QIN NCC), and frequently asked questions related to revision of the State Operations Manual Appendix PP for Phase 2 of the Reform of Requirements for Long-Term Care Facilities final rule. A question and answer session will follow the presentation. The slides for the MLN call are now available here, and the slides include a link to the facility assessment tool which can be found here: http://qioprogram.org/facility-assessment-tool.

11) The latest Telligen events/announcements can be found at https://www.telligenqinqio.com/.

12) The Journal of Post-Acute and Long-Term Care Medicine (JAMDA) reports on Important Care and Activity Preferences in a Nationally Representative Sample of Nursing Home Residents. Findings demonstrate the PAT captures variation in preferences across items and residents. Residents with possible depression and cognitive impairment were less likely to rate preferences important than residents without those conditions. Non-Caucasian and male residents reported some preferences differently than Caucasian and female residents. Additional assessment and care planning may be important for these residents. More research is needed to determine the factors that influence preferences and the ways to incorporate them into care.

13) The Hill reports that America Should Address Its Impending Nursing Shortage Before It’s Too Late. Contributor Sheldon D. Fields writes for The Hill "Congress Blog" that America’s rapidly growing elderly population soon "will put enormous strain" on the nation’s "ill-prepared" health care system. Fields cites "America’s looming nurse shortage" as a primary example, adding that America’s nursing schools aren’t supplying "nearly enough" nurses to meet future
Demand. Fields suggests more federally-funded nursing development programs, nurse loan forgiveness plans, and reduced "regulatory barriers" to nursing, among several ways to address the nursing shortage before America's health system is "pushed past the breaking point."

14) The Hanford (CA) Sentinel reports that Nursing Homes Begin to Move Into the Insurance Business. According to the Hanford (CA) Sentinel, some nursing home companies around the country have "begun selling their own private Medicare insurance policies," promising close coordination and giving clinicians more authority over which treatments will be covered for patients. The article states that these plans are new additions to the Medicare Advantage market, and differ from other offerings by often placing a "nurse in the skilled nursing facility or retirement village, where they can talk directly to staff and assess patients' conditions." Vice President of Quality at PruittHealth Angie Tolbert said, "The traditional model is making decisions based on paper, and in our model, these decisions are being made by clinicians who are really talking to the staff and seeing the patient." Washington health care consultant Anne Tumlinson said when a nursing home’s company is responsible for the cost of hospitalization of its patients, it is more likely to take efforts to prevent stays.

15) USA Today reports that The Retina May Serve as a Reliable Source for Alzheimer’s Disease Diagnosis. USA Today recently featured an article that stated that the eye’s "retina may serve as a reliable source for Alzheimer’s disease diagnosis," researchers concluded. Alzheimer's appears to affect the retina "similarly to how it affects the brain," investigators found. Using "a high-definition eye scan," investigators "found they could see buildup of toxic proteins, which are indicative of Alzheimer’s." The findings were published online in the journal JCI Insight. Aunt Minnie also covers the study.

16) Medscape reports that Better Assessments Needed Before Initiating Antibiotics in Suspected UTI Cases in Nursing Homes. In a Medscape op-ed, Margaret R. Nolan, DNP, GNP, writes that patients residing in long term care (LTC) facilities often receive "unnecessary treatment with antibiotics" because urinalysis fails to differentiate "between a UTI and asymptomatic bacteriuria," which ultimately raises "the risk for antibiotic resistance." Nolan writes that the Cooper Urinary Surveillance Tool, "a novel evidence-based algorithm that guides LTC nurses in their assessment" of UTIs in residents, "significantly reduced the rate of UTI diagnoses and reduced inappropriate" UTI diagnoses in a recent project at the University of Michigan. Nolan says the success of the tool supports the need for "more clear and consistent" patient assessments for UTIs before antibiotics are administered.

17) ModernHealthcare reports that the Medicare Shared-Savings Program Saved $1 Billion Over Three Years. ModernHealthcare says that HHS’ Office of Inspector General released a report Tuesday discussing how accountable care organizations (ACOs) participating in CMS’ Medicare shared-savings program reduced spending by $1 billion in the first three years of the program. CMS data show two-thirds of the 428 participating ACOs reduced their spending in at least one of the years during which they participated, and one-third of the ACOs reduced spending enough to receive a portion of the savings back to "invest in new care programs, provide incentives to providers to improve quality, or update their electronic health records." Most of the ACOs, 82 percent, improved the quality of care that they provided. The article adds that the ACOs "outperformed fee-for-service providers in 81 percent of the quality measures."

18) The AP reports that 28.1 Million Americans Lack Health Coverage. The AP reports that according to a report from the Centers for Disease Control and Prevention, 28.1 million people were uninsured from January-March, down about 500,000 from the previous quarter. The number is a drop from the 48.6 million uninsured people since the Affordable Care Act passed in 2010.

19) Reuters reports on:

- Smoking Linked to Frailty in Older Adults. Reuters reported that a study published in Age and Ageing finds "older adults who smoke are more likely to become physically frail than their counterparts who are former smokers or never used tobacco products." They also found that those who had quit smoking had a lesser risk of frailty than those who had not, suggesting that quitting smoking could potentially reduce the risk of becoming frail.
Chronic Gum Inflammation May be Associated With Higher Risk of Alzheimer’s Disease. Reuters reports that research suggests "chronic gum inflammation" may be linked to "an increased risk of developing Alzheimer’s disease." Investigators "found no overall link between periodontitis and Alzheimer’s, but people who had" periodontitis "for 10 or more years were 70 percent more likely than people without periodontitis to develop Alzheimer’s disease." The findings were published in Alzheimer’s Research and Therapy.

Provider Magazine reports on:

- Lung Diseases Can Lead to Residents’ Physical, Emotional Disturbances. Provider Magazine reported comments from Albert Rizzo, MD, senior medical adviser at the American Lung Association, concerning the need for long term and post-acute care providers to be aware of "the web of physical and mental health problems" that residents with lung diseases often have. Dr. Rizzo told Provider that with conditions such as chronic obstructive pulmonary disease, "despite what doctors can do, there is more shortness of breath and people in turn start doing less activity," which can lead to a sedentary lifestyle that in turn contributes to less independence for residents, "which can lead to depression and even less activity. It is a cycle really." He advocated for physical therapy and counseling for residents with such conditions.

- Patients in CMS Joint Replacement Bundle Program Show Higher Risk of Hospital Readmissions. Provider Magazine reports a study (PDF) by Leavitt Partners found that patients included in CMS’ Comprehensive Joint Replacement (CJR) bundle program have the highest risk of readmissions during the first 30 days following their discharge from a hospital. According to Leavitt, "5.1 percent of CJR patients returned to the hospital within the first 30 days, while 2 percent returned between days 31 and 60, and less than 2 percent in the following 30-day increments, up to a cumulative total of 11.7 percent of patients returning by day 180." The study also found that hospital readmissions are "more common with five chronic conditions: anemia, chronic kidney disease, viral hepatitis, pressure and chronic ulcers, and chronic pulmonary disease and bronchiectasis."

- AHCA: Resident Classification System (RCS) Would “Create More Issues Than Improvements.” Provider Magazine reports that CMS "is seeking feedback on its Advanced Notice of Proposed Rulemaking (ANPRM) for the proposed Resident Classification System (RCS), which was written during the Obama administration." The intent of the RCS "is to simplify the annual reimbursement update for SNF operators in the Medicare program. However, in its response to CMS, the American Health Care Association (AHCA) said the change would do the opposite." The AHCA said, "In short, we do not view the current proposal as an improvement over the existing PPS other than addressing a single, but important issue—therapy utilization. Other than creating incentives to decrease therapy utilization, RCS simply would create more issues than improvements for beneficiaries, providers, and the Medicare program." The basis of AHCA’s concerns "rests on the CMS data and related analytics meant to support the new payment model."

Kaiser reports:

- Medicare Beneficiaries Participated in More End-Of-Life Consultations Than Anticipated. Kaiser Health News reported on "end-of-life consultations" that were "paid for by Medicare" for the first time in 2016. The article says "nearly 575,000 Medicare beneficiaries" participated in the consultations in 2016, according to federal data, and "nearly 23,000 providers submitted about $93 million in charges" as a result. Use of the program almost "double[d] the 300,000 people the American Medical Association projected would receive the service in the first year," the story adds.

- Hospice-Prescribed Painkillers Commonly Stolen by Family Members. The Kaiser Health News reports on the growing problem of hospice-prescribed painkillers "ending up in the wrong hands." The article says hospices have "little oversight" and "in most states...have little control over" prescribed pain medications "after a patient dies," rendering it easy for family members to steal leftover pills. The article says some states have approved laws allowing hospice staff "to destroy unused drugs after patients die" in an effort to combat misuse, and many hospices say they attempt precautions such as "limiting the volume" of painkillers delivered and having nurses count pills during visits.
22) **HealthDay** reports:

- **Many Seniors May Not Hear Everything Physicians Say, Which Could Increase the Likelihood of Medical Errors.** *HealthDay* reports that a study suggests "many seniors may not hear everything their" physicians "tell them...and that could raise the risk of medical errors." The study indicated that "the main types of mishearing included misunderstanding what was said to them, not correctly hearing a doctor’s diagnosis or advice, and general breakdown in doctor-to-patient communication..." said researcher Simon Smith. The findings were published in *JAMA Otolaryngology--Head & Neck Surgery*.

- **Lower Systolic Blood Pressure Target for Older People May Offer Cognitive Benefits.** *HealthDay* reports that research published in *JAMA Neurology* suggests "for seniors, and particularly" black patients, with hypertension, "lowering it may help keep their minds sharp."

- **'Confusion' Complicates Hospitalization of Elderly.** Older adults with confusion are more likely to remain in the hospital longer once they are admitted, and are more likely to die, a new study finds. "People with confusion -- or cognitive spectrum disorders -- make up over one-third of the population over 65 [in the U.K.] who are admitted as an emergency to the hospital, and half of patients over the age of 85 years," said the study's lead researcher, Prof. Emma Reynish. These patients seem to do badly, and are at an increased risk of a hospital stay nearly two weeks longer than those without confusion, said Reynish, chair of dementia studies at the University of Stirling in Scotland.

23) **MedlinePlus** reports:

- **Sitting Could be Big Health Risk for Frail Folks.** After years of being told that sitting too much is deadly, a new study now suggests that being sedentary for long periods of time may not be an equal-opportunity health risk. For inactive middle-aged and older people with multiple health problems, being sedentary does appear to be linked to an increased risk of early death. But sitting a lot doesn't seem to affect active people the same way, the researchers said.

- **Longer Prescriptions Make Opioid Abuse More Likely.** A short-term painkiller prescription is less likely to lead to opioid use disorder than a longer supply of pain pills, a new study suggests. "Compared to someone prescribed two days versus seven days, that person with a seven-day supply is twice as likely to be using opioids in the long term," said study senior author Bradley Martin. After looking at a decade's worth of medical records, Martin and his team concluded that "the days supplied is far more important than the dosage level or even the type of pain being treated."

- **More Than Half of Americans Will Need Nursing Home Care.** More than half of Americans will find themselves in a nursing home at some point in their lives, a new study shows. That eclipses the 35 percent estimate used by the U.S. Department of Health and Human Services, the researchers added. "Lifetime use of nursing homes is considerably greater than previously thought, mostly due to an increase in short stays of less than three weeks," said lead researcher Michael Hurd. He is director of the RAND Center for the Study of Aging, in Santa Monica, California. Increased nursing home care begs the question of who will pay for it and how will they pay for it, he said.

24) **McKnight’s** reports:

- **Employees Say Workplace Culture, Teamwork Influence Job Satisfaction More Than Labor Contracts.** *McKnight’s Long Term Care News* reports that a study published in Health Care Management Review found that workplace culture and teamwork dynamics contribute more to employee satisfaction on both individual and facility-wide levels than labor contracts. The researchers wrote "aides of the [nursing homes] with the contract having the best conditions register a significantly lower level of satisfaction compared to the NHs with the worst contract conditions."
• Polypharmacy Among SNF Residents May Increase Risk of Being Diagnosed With Hypertension, Diabetes. *McKnight’s Long Term Care News* reports that a study published in *BMJ Open* by Canadian researchers found polypharmacy may contribute to nursing home residents’ overtreatment for hypertension and diabetes. Among residents who regularly took nine or more medications, the likelihood of being diagnosed with hypertension increased. Researchers "also found a statistically significant link between polypharmacy and overtreatment for blood pressure issues."

• CMS to Modify Medicare Audit Process to Ease Burden on Providers. *McKnight’s Long Term Care News* reports that CMS announced it is overhauling its Medicare audit system to alleviate the burden on providers. CMS introduced a "targeted probe and educated medical review strategy," under which Medicare Administrative Contractors will concentrate on providers "who have the highest claim error rates or billing practices that vary significantly out from their peers."

• Verma Discusses Decreasing Regulatory Practices that "Burden" Providers. *McKnight’s Long Term Care News* reports that CMS Administrator Seema Verma wrote in a blog post recently that the agency "must make it easier" for care providers to accomplish their work "without causing them to be subject to excessive regulatory and administrative burden." Verma discussed efforts to simplify regulations which she said will "ease the burden our government places on health care providers," and distinguish between necessary regulations and those that "have tilted more towards creating burdens than towards serving as a safeguard for the programs," such as "unnecessarily time-consuming" payment and quality reporting documentation.

• APRN Beneficial for Improving SNF Care. *McKnight’s Long Term Care News* reports that a study published in the July/September issue of the *Journal of Nursing Care Quality* suggests offering advanced practice nurses training in leading nursing home care teams can improve staff communication and facility operations for mobility, hydration, and end-of-life care issues. The study followed the Missouri Quality Initiative for Nursing Homes, which is in its fifth year and includes placing APRNs at SNFs "to gauge how their skills influenced care coordination." Researchers found "12 of the 16 facilities reported reductions in hospitalizations rates since hiring an APRN."

• Report Finds Self-Neglect Most Common Type of Elder Abuse. *McKnight’s Senior Living* reports on a federal study released by the National Adult Maltreatment Reporting System, which collects data from voluntary participants. The investigation revealed that "self-neglect was by far the most common type of maltreatment investigated by state and local adult protective services programs in 2016." According to the Administration for Community Living, "the report contains the first consistently, systematically and nationally collected data on the abuse of older adults and adults with disabilities."

• Report: More Than 25 Percent of Potential Abuse Incidents in SNFs Go Unreported to Police. More than a quarter of incidents of possible abuse or neglect against nursing home residents go unreported to authorities despite mandatory reporting laws, according to a new federal report. The report was created as part of an ongoing review into abuse in nursing homes by the Department of Health and Human Services’ Office of Inspector General. Preliminary findings were released as an “early alert” to CMS Administrator Seema Verma “because of the importance of detecting and combating elder abuse,” officials said.

• Court Tells EEOC to Reconsider Work[place Wellness Plan Incentives. The AARP is calling a federal court’s decision to have the Equal Employment Opportunity Commission reconsider workplace wellness plan incentives “a tremendous victory for workers,” although the final outcome in the matter remains to be seen. AARP sued the EEOC in October after the agency issued new rules the previous May indicating that employers could provide financial and other incentives to employees who answered questions related to disabilities or underwent medical exams as part of a wellness program, whether or not the program was part of a health plan. The agency capped cost incentives for participating workers at 30 percent. The rules, which reversed previous policy, went into effect Jan 1.
25) **Interesting Fact:** There are more lifeforms living on your skin than there are people on the planet. After writing this, I now have an irresistible urge to itch???